

Summary: State Plan for the Implementation of the Marcus-David Peters Act

Overview of the Marcus-David Peters Act

The Marcus-David Peters Act is named in honor of Marcus-David Peters, a young, Black, biology teacher and VCU graduate who was fatally shot by Richmond Police in 2018 in the midst of a behavioral health crisis; it was signed into law in November 2020 by Governor Northam. The Act modifies Code of Virginia to add **§ 9.1-193. *Mental health awareness response and community understanding services (Marcus) alert system; law-enforcement protocols***, which outlines the role of DCJS and local law enforcement in the development of three protocols for behavioral health crisis situations, sets seventeen goals for law enforcement participation in the Marcus Alert system, assigns purview between DCJS and DBHDS, and requires localities to develop a voluntary database. The Act also modifies Code of Virginia to add **§ 37.2-311.1. *Comprehensive crisis system; Marcus alert system; powers and duties of the Department related to comprehensive mental health, substance abuse, and developmental disability crisis services***. This requires DBHDS to develop a comprehensive crisis system based on national best practice models and composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus Alert system. It also requires DBHDS, in collaboration with DCJS and a range of stakeholders, to develop a written plan for the development of the Marcus Alert system, which is represented in this document and described further in the full state plan for implementation of the Marcus-David Peters Act.

It is important to note that the Marcus-David Peters Act refers to the Act in its entirety, including state components of the comprehensive crisis system as well as the requirements for each local Marcus Alert system which is primarily defined as three protocols.

Summary and Overview of State Implementation Plan

The state plan for the implementation of the Marcus-David Peters Act is the result of a collaborative process between Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Criminal Justice Services, other state agency partners, and the Marcus Alert State Planning Stakeholder Group. The group was comprised of 45 stakeholders from across Virginia, representing local government, non-profit, private, community, lived experience, and advocacy in the areas of mental health, law enforcement, crisis intervention teams (CIT), developmental disabilities, substance use disorder, social justice and racial equity, as well as 20 state government representatives and other *ex officio* group members.

The state plan includes four broad sections. The first section provides a vision for Virginia's behavioral health crisis system, a summary of the planning group and process, and a current landscape analysis. The landscape analysis includes, as required, a catalog of existing CIT programs, crisis stabilization programs, cooperative agreements between law enforcement and behavioral health, a review of the prevalence and estimates of crisis situations across Virginia, and current funding for crisis and emergency services. The second and third sections provide information on State Components of the Plan (Section II) and Requirements for local Marcus Alert Systems (Section III). Due to the interconnections and overlapping timelines between the state components of the comprehensive crisis system and the local protocols for the Marcus Alert system, this report provides an overview of the state components, which are necessary but not sufficient to implement the Act, as well as the specific requirements which localities, including the initial 5 areas, are responsible for implementing to develop their local Marcus Alert system development. This distinction is made because the state components of the plan are not the responsibility of the initial 5 areas or any localities to implement directly; rather it is the responsibility of DBHDS to implement these components and align the timelines for implementation to ensure that the local Marcus Alert system protocols are able to transfer calls and divert and connect individuals to the comprehensive crisis system. The state-level components described in Section II include a four-level framework for categorizing crisis situations, regional coverage by STEP-VA mobile crisis teams and associated Medicaid rates, 9-8-8 and regional call center implementation, a statewide Equity at Intercept 0 Initiative, and statewide training standards. The local level requirements described in Section III include the local planning process, minimum standards and best practices for local law enforcement involvement in the Marcus Alert system, descriptions of different ways to achieve local

community coverage, and the system for review and approval of protocols. These are the components which the first 5 areas will be implementing by December, 2021. Finally, the fourth section provides frameworks for accountability and responsibility across state and local entities and how the success of the Marcus Alert system will be evaluated.

Summary of Section I: Vision, Process, and Current Landscape Analysis

The existing behavioral health crisis system in Virginia has multiple, disparate ways for people in crisis to access care, and multiple ways for the people who are staffing the crisis system to receive, assess, triage, and record these calls for care. Local community services boards/behavioral health authorities receive calls through more than 40 distinct telephone numbers bifurcated by disability, age, and even specific crisis situation. This “patchwork” of access points is often confusing to the person in need of crisis services and creates multiple hurdles to access help and get appropriate care instead of a single point of entry that is outside of 911. This has contributed to an over-reliance on 911, law enforcement, and high-acuity, high cost services such as inpatient hospitalization. There is significant momentum to address Virginia’s long standing challenges and overutilization of high-acuity, high-cost services and to build an evidence-based continuum of behavioral health care that features high quality services, including comprehensive crisis services and a crisis access line. The vision for Virginia’s future crisis system is to keep Virginians well and thriving in their communities, meet people’s needs in environments where they already seek support, provide care in the least restrictive environment, and optimize taxpayer dollars by investing in crisis prevention and crisis early intervention of mental health problems and crises. This includes a system that:

- *Aligns with national best practices to serve people in the least restrictive setting possible and build on their natural supports*
- *Is centered on principles of trauma-informed care and the belief that people can and do recover*
- *Serves people regardless of disability or diagnosis, and across the life span*
- *Reduces the use of hospital emergency departments, jail bookings, and unnecessary hospitalizations*
- *Supports crisis-trained first responders to support individuals in crisis and link them to the crisis system, decreasing reliance on law enforcement as the de facto crisis response*

Understanding the current landscape is an essential first step in improving Virginia’s crisis response system. To that end, an inventory survey was disseminated to community services boards (CSB), CIT

programs, public safety answering points (PSAP), and law enforcement (LE) agencies. Of the entities that were contacted, 45% of CIT programs, 70% of CSBs, 24% of LE agencies, and 48% of PSAPs responded to the survey. The review of existing programs indicated that some key components of this system are present in Virginia, but there are significant gaps in access, availability, and coordinating infrastructure. For instance, among the 28 CSB respondents, 19 youth mobile crisis teams were reported, reflecting recent investments made through STEP-VA. Nonetheless, of the 19 youth mobile crisis teams reported by CSB respondents, only one was reported to operate twenty-four hours per day, seven days per week. Similarly, the four existing co-response teams with LE that were reported by CSB respondents only operate Monday through Friday, not on weekends. The situation is similar for physical resources (“somewhere to go”): While there are at least two crisis stabilization units (CSU) in each of the DBHDS regions, CSU licensed bed capacity is 16 beds or less. Nonetheless, there is a desire to work collaboratively across professions to improve Virginia’s crisis response system—as evidenced by the existence of interdisciplinary committees that review how best to serve individuals who frequently interface with the crisis system often (e.g., dialing 9-1-1 often).

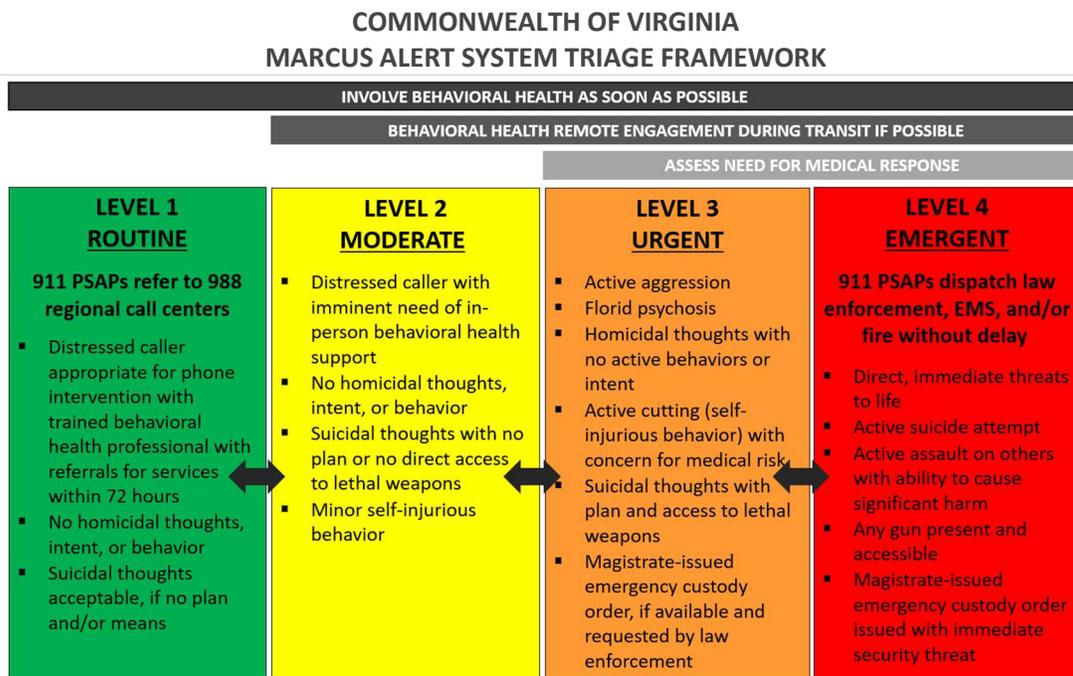
Estimating the prevalence of crisis situations across Virginia is difficult, but estimates across levels of acuity are provided for CSB catchment areas and localities. Currently, between 4,300 (April) and 7,400 (October) crisis evaluations are completed monthly through CSB emergency services. Thirty percent of these occur under an Emergency Custody Order (ECO). Thirty one percent of these result in a Temporary Detention Order (TDO), and there are approximately 2,000 TDOs statewide per month. When considering the broader range of crisis situations, including those who can be managed with phone support and linkage to services, the Crisis Now [Crisis Resource Need Calculator](#) would estimate that there are 17,000 Virginians in crisis statewide per month. This would indicate that there is currently approximately 30-40% penetration of emergency services evaluations into the spectrum of crisis situations, and those crises which are being evaluated are skewed dramatically towards the severe end of the crisis spectrum. This highlights two things: first, the critical role of an accessible, statewide phone line (9-8-8) to connect to the crisis system, and second, the extent to which mobile crisis services and stabilization services must be built statewide to achieve the desired statewide behavioral health response system. As one example, the Crisis Now assessment suggests that Virginia would need 346 short term beds (e.g., crisis stabilization unit beds), 406 chairs for 23-hour observation statewide, and at least 68 mobile crisis teams each responding to 4 crises per day. It is important to note that these estimation tools are in their infancy.

Summary of Section II: State Level Plan Components

There are six state-level components of the implementation plan. These include a four-level urgency triage framework for assessing risk level and communicating across entities; the development of statewide coverage by STEP-VA mobile crisis teams that are employed by the regional crisis hubs; federal 9-8-8 and regional call center implementation; a statewide Equity at Intercept 0 Initiative; statewide training standards across behavioral health, law enforcement, PSAP, and other participants in crisis response/local Marcus Alert systems; and a statewide public service campaign that focuses on raising community awareness for the use of 9-8-8 as a way to access behavioral health supports in times of stress and crisis.

Four Level Urgency Triage

A four level urgency triage framework was developed and the four levels (Marcus Alert level 1, 2, 3, and 4) are used throughout the state plan to support shared communication across sectors, to provide a framework for planning different responses at the local level and communicating local plans to DBHDS and DCJS in a fashion that can be understood across the state, and for reporting and evaluation purposes. Each PSAP will need to integrate coding for these levels into the CAD for reporting purposes. The four level urgency triage is the framework local Marcus Alert systems will build their different protocols and specialized responses around. An overview is provided in this graphic:

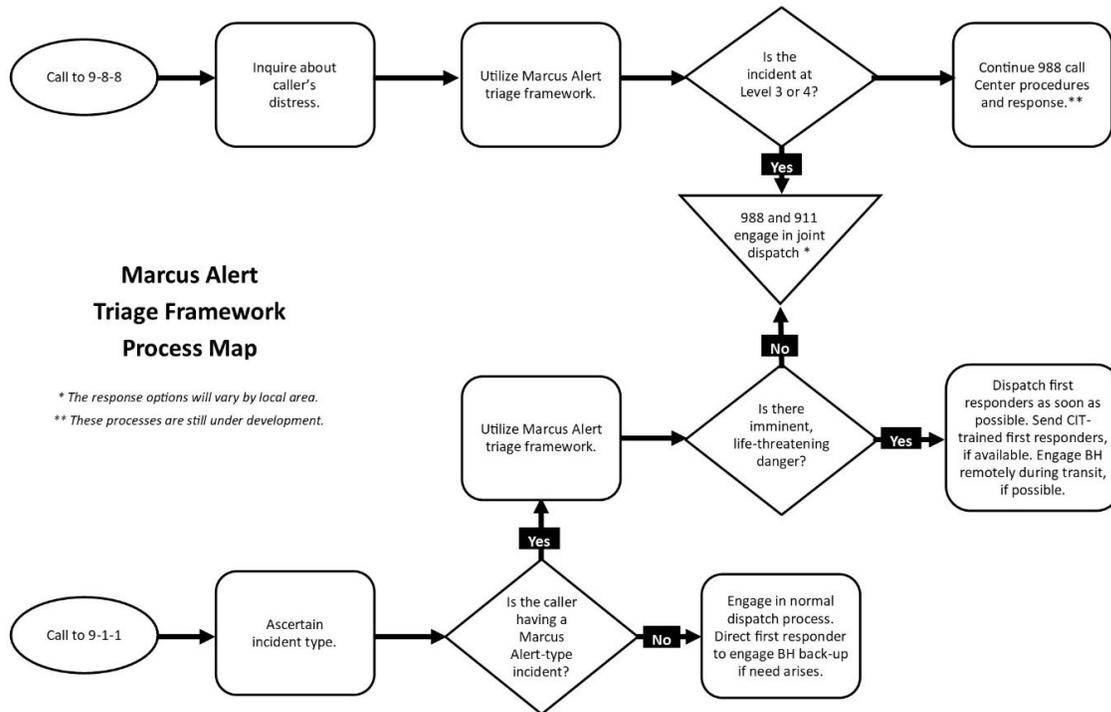


STEP-VA/BRAVO Mobile Crisis Coverage

The second state component of the implementation plan is the development of statewide coverage by STEP-VA mobile crisis teams that are employed by the regional crisis hubs. These teams do not have law enforcement members but can call for law enforcement back up, and are characterized by a one hour response time (up to 90 minutes in rural areas) and consideration of law enforcement referrals as “preferred customers” with quicker response times. Private providers of mobile crisis services will also be under agreement with the regional crisis hubs so that they can be dispatched through the 9-8-8 system. Funds for STEP-VA adult mobile crisis teams will be disbursed to regions beginning July, 2021, thus, teams will be being built and trained as initial areas are implementing their local Marcus Alert systems. BRAVO rates are projected to be online in the Medicaid plan December 1, 2021, to coincide with the initial area implementations.

9-8-8 and Regional Call Centers

The third component of the implementation plan at the state level is the implementation of 9-8-8 as a three digit number to access crisis services. Federally, it is required that 9-8-8 be accessible July 16, 2022 to, at a minimum, the National Suicide Prevention Lifeline supports and services. Virginia accepted bids on a request for proposals for a crisis call center platform, which is a key component of these system components working as an integrated system, which is expected to be implemented by December, 2021. In other words, initial areas will set up their local Marcus Alert system plans with the expectation that 9-8-8 will be accessible, although early in implementation, as they launch their local systems. The 9-8-8 line will be managed by 5 regional call centers which are under the purview of 5 CSBs representing their DBHDS regions: Region 10 CSB (Region 1), Fairfax-Falls Church (Region 2), New River Valley (Region 3), Richmond Behavioral Health Authority (RBHA; Region 4), and Western Tidewater (Region 5). Below is a high level heuristic of how local PSAPs and 9-8-8 call centers will set up procedures for call transfers and coordination:



Equity at Intercept 0 Initiative

The fourth state component of the implementation plan is a statewide Equity at Intercept 0 Initiative, which is focused on building supports for public-private collaboration in Virginia’s publicly funded crisis services, and seeks to develop infrastructure for training and development to ensure small, community focused providers (with a focus on Black-led, BIPOC led, and peer led providers) are integrated into the crisis services system, including training and academic partnerships, partnerships around language access, and other critical projects to ensure equitable access to community-based crisis services. The Equity at Intercept 0 Initiative also supports the development of a Black-led state crisis coalition which will work with the Equity at Intercept 0 network leads but also play a role in review and ongoing development of the Marcus Alert implementation.

Statewide Training Standards

The fifth state level component refers to statewide training standards across behavioral health, law enforcement, PSAP, and other participants in the crisis response system or any local Marcus Alert system. It is a local requirement that these training standards be adhered to, but the plan is to develop standards at the state level to ensure high quality and consistent training throughout the state. Basic

behavioral health requirements will be primarily built into developing mobile crisis training curriculums (STEP-VA). Because DCJS is required to collaborate with DBHDS on Marcus Alert development and training, and also has recently enhanced purview over the review of academy curriculum and lesson plans for both basic and in service training with a particular emphasis on topics relevant to the Marcus Alert, the most logical course of action is for DBHDS and DCJS to enter into an agreement regarding DBHDS, Equity at Intercept 0, and Black-led coalition input onto Marcus Alert training requirements. This agreement will be pursued during the first year of implementation. Dispatch training will be developed in tandem with the call center training being developed for 9-8-8/regional call center staff. This RFP will designate a module that provides the information appropriate for 9-1-1 call takers to understand about 9-8-8 and basic mental health training. That module will constitute the basic/required training for PSAP staff, and PSAP staff are also welcome and encouraged to participate in the advanced Marcus Alert training.

Overview of Basic Behavioral Health Training Requirements and Competencies*

Empowerment and Engagement	Assessment	Clinical Interventions	Cultural Competency	Disability Justice	Basic Marcus alert principles
<ul style="list-style-type: none"> • recovery principles • harm reduction • trauma-informed and trauma-sensitive practices 	<ul style="list-style-type: none"> • trauma sensitive assessment • collateral information • substance use assessment • cognitive impairment • risk assessment • level of care assessment 	<ul style="list-style-type: none"> • treatment of acute agitation • safety planning • de-escalation • motivational interviewing, • treatment of intoxication and withdrawal including coordination with medical • Crisis resolution 	<ul style="list-style-type: none"> • Racial identity development • cultural humility • implicit bias • historical trauma • family dynamics and working with natural supports • anti-racism • health disparities in behavioral health 	<ul style="list-style-type: none"> • Federal and state structures and protections • ableism • dignity of risk • intersection of disability justice and criminal justice 	<ul style="list-style-type: none"> • Basics of MA requirements • intersectional considerations • advanced empowerment techniques • mitigating implicit bias in the context of behavioral health crisis response

**will be integrated into required Mobile Crisis Basic Training curriculum (required for all Mobile Crisis providers and behavioral health community care team members)*

Overview of Basic and In-service Law Enforcement Training Requirements and Competencies

<p>De-escalation training and techniques</p> <ul style="list-style-type: none"> • To be required under DCJS uniform curriculum • Basic academy • In-service 	<p>Working with individuals with mental health and substance use disorder</p> <ul style="list-style-type: none"> • To be required under DCJS uniform curriculum • Basic academy • In-service 	<p>Working with individuals with developmental disabilities</p> <ul style="list-style-type: none"> • To be required under DCJS uniform curriculum • Basic academy • In-service 	<p>Cultural diversity, bias-based policing, implicit bias</p> <ul style="list-style-type: none"> • To be required under DCJS uniform curriculum • Basic academy • In-service 	<p>Use of force in context of behavioral health crises</p> <ul style="list-style-type: none"> • To be required under DCJS uniform curriculum • Basic academy • In-service
--	---	---	---	--

Overview of Advanced Marcus Alert Training Requirements and Competencies*

<p>Cultural humility and historical trauma</p> <ul style="list-style-type: none"> • Intrapersonal, interpersonal, and systems level cultural humility • Trauma and traumatic stress basics, including racialized trauma 	<p>Disability Justice</p> <ul style="list-style-type: none"> • Federal and state structures and protections across professions • ableism • dignity of risk • intersection of disability justice and criminal justice 	<p>Anti-racism</p> <ul style="list-style-type: none"> • Racial identity development • Health impacts of racism • Advanced mitigation strategies for race-based bias 	<p>Intersection of Implicit Bias and Crisis Response</p> <ul style="list-style-type: none"> • Intersections of risk assessment, implicit bias, family wellness perceptions • guardian vs. warrior, implicit bias 	<p>Intersection of De-escalation, Bias, Workforce Wellness</p> <ul style="list-style-type: none"> • Burnout and stress • Power and control • De-escalation (experiential strategies) • Intersection of personal burnout and implicit bias
---	--	--	--	---

**These trainings are not integrated into basic behavioral health or law enforcement requirements. A competitive RFP will be posted for a vendor to develop a high quality training and training manual. Advanced Marcus Alert trainings are projected to begin July, 2022. All professions involved in the Marcus Alert system are eligible for the training.*

State Public Service Campaign

Finally, there is a sixth statewide component regarding a public service campaign that focuses on raising community awareness for the use of 9-8-8 as a way to access behavioral health supports in

times of stress and crisis. Results of a community input survey conducted as part of the planning process indicated that primary reasons for avoiding seeking help during a behavioral health crisis were the lack of control over what happens when help is sought in a behavioral health crisis, not wanting to be hospitalized, negative experiences with behavioral healthcare in the past, not wanting to be handcuffed, and past negative experiences with calling 9-1-1 for a behavioral health emergency. Respondents were also asked about their preferred options for handling the crisis (if all these options were available), and the most preferred responses among those with personal experience were to call a hotline where a trained behavioral health professional (social worker, counselor, peer recovery specialist, etc.) can speak for at least 30 minutes over the phone (19%), call and receive an immediate telehealth appointment with a behavioral health professional (18%), call a hotline and receive a same-day, in-person appointment with a therapist (14%), and call a hotline and talk with a peer recovery specialist over the phone (12%). These results, combined with state laws outlining ECOs and TDOs and the local variability that will exist in Marcus Alert protocols led the group to conclude that a primary message that should be provided to the public is about 9-8-8, and the importance of calling early in a crisis and the range of lower level supports that will be available, such as phone based supports.

Summary of Section III: Local Marcus Alert System requirements, Minimum Standards and Best Practices

There are approximately eight components of the implementation plan that are the responsibility of local areas to implement. The local Marcus Alert system is described in the Act as *“a set of protocols to (i) initiate a behavioral health response to a behavioral health crisis, including for individuals experiencing a behavioral health crisis secondary to mental illness, substance abuse, developmental disabilities, or any combination thereof; (ii) divert such individuals to behavioral health or developmental services system whenever feasible; and (iii) facilitate a specialized response in accordance with § 9.1-193 when diversion is not feasible.”* There are five areas that must implement their Marcus Alert system by December, 2021. All other areas must implement the protocols by July 1, 2022, whereas community coverage by different response teams is required on a phased-in timeline. The eight local components include local planning guidelines, voluntary database development, protocol #1, protocol #2, protocol #3, community coverage, and the submission and approval process, which includes a consolidated list of minimum standards across the different local requirements.

Local Planning Guidelines

First, there are guidelines for local planning group formation and initial planning activities, including crosswalking the four-level urgency triage levels to existing PSAP specifications. The five steps of the recommended planning process are provided in the Community Planning Roadmap and represented here:



Voluntary Database

Second, there is a description of the voluntary database which is required for each 9-1-1 center. Per the Act:

F. By July 1, 2021, every locality shall establish a voluntary database to be made available to the 9-1-1 alert system and the Marcus alert system to provide relevant mental health information and emergency contact information for appropriate response to an emergency or crisis. Identifying and health information concerning behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury may be voluntarily provided to the database by the individual with the behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury; the parent or legal guardian of such individual if the individual is under the age of 18; or a person appointed the guardian of such person as defined in § 64.2-2000. An individual shall be removed from the database when he reaches the age of 18, unless he or his guardian, as defined in § 64.2-2000, requests that the individual remain in the database. Information provided to the database shall not be used for any other purpose except as set forth in this subsection.

Localities can determine solutions based on consultation between 9-1-1, behavioral health, and law enforcement. Localities may consider software solutions which allow for individuals to provide

information to 9-1-1 dispatch, or can build a database related to existing lists (e.g., hazard lists or information associated with addresses), or create a new database that meets the requirements state in the Act. It is recommended that localities consult with their legal staff ensuring that there are no privacy or HIPAA concerns.

Protocol #1

Protocol #1 refers to the first local protocol required, which is a protocol to transfer calls from 9-1-1 to 9-8-8 regional call centers. To meet the minimum standards for Protocol #1, PSAPs must integrate the four level urgency triage framework into their technical specifications and set policies and workflows to ensure that calls can be transferred from 9-1-1 to 9-8-8. The minimum standard is that Level 1 calls are diverted to 9-8-8. For Protocol #1, it is recommended that Level 2 calls are also coordinated between 9-1-1 and 9-8-8, and that a Poison Control Model be explored as a potential parallel for coordinating between entities in general (across levels).

Protocol #2

Protocol #2 refers to the second local protocol required, which is an agreement (and associated policies and procedures) to serve as back up to behavioral health mobile crisis teams. Marcus Alert Protocol #2 will ensure that there are clear expectations between the mobile crisis regional hub and any law enforcement back-up. The regional mobile crisis hubs will take the lead on structuring these agreements with law enforcement partners, for example, it may be one standard agreement which could be signed by any law enforcement agency able to provide back up as needed within that area. Initial funding for the development of these call centers and hubs will begin July 1, 2021, thus, these hubs are in an early development phase and these agreements can be developed over the first 12 months of implementation to meet the Marcus Alert requirement of July 1, 2022. From a technical perspective, agreements between the regional call centers and law enforcement agencies providing back up must include these four following components at a minimum: technical processes needed to request back-up in the most efficient manner possible; procedures for communicating between behavioral health and law enforcement to provide details of the scene and ensure that there is shared understanding of the situation and the request for back up before back up arrives (i.e., treatment before tragedy custody function, treatment before tragedy restraint/force function, or protection for other individuals involved from an individual in crisis posing a safety risk to others); clear information regarding what training any back-up sent will have; responsibilities for both parties under the MOU. It is

recommended that agreements include provisions that law enforcement staffing patterns will be set (e.g., discussed and calibrated at quarterly cross-agency meetings) to support goal that back-up officers sent will be voluntarily CIT trained or have received the advanced Marcus Alert training.

Protocol #3

Protocol #3 refers to the third required local protocol which requires that all law enforcement agencies have a specialized response when responding to a behavioral health emergency. This means that in situations where law enforcement is responding to a situation, whether or not there are any behavioral health teams or providers on scene, law enforcement agencies must have specialized requirements. Specialized response protocols are submitted in the context of a systems approach to supporting individuals in behavioral health crisis:

Law Enforcement: Organizational approach to serving community members with behavioral health needs



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf> (Balfour, 2020)

There is not currently evidence of a single protocol or stand-alone program to provide this function for communities, instead, it is accepted that it is a systems problem and protections should be built into all levels of the system to continually decrease risk of tragedy. Additional policies which may be impacted by the implementation of Protocol #3 include agency ADA policies, or “Responses to Persons with Mental Illness” policies. Specialized responses must take into consideration the needs of individuals with mental health and substance use disorders, developmental disabilities, brain injuries, and the specific needs of youth. Protocol #3 is required by July 1, 2022 statewide. Thus, a specialized response must be available by that date, even if additional community coverage by teams is expected to be developed beyond that date (e.g., if an area has a full implementation date of 2024 or 2026).

Achieving Community Coverage

Per this plan, statewide coverage by mobile crisis teams will be achieved through STEP-VA/BRAVO implementation. Thus, it is not required that areas implement additional teams in their submitted plans, rather, coverage can be achieved by linking policies and procedures to coordinate with STEP-VA/BRAVO mobile crisis teams. This may include coordination such as Poison Control Model (described in Protocol #1) or use of telehealth/remote intervention. However, to achieve robust coverage across the four triage levels, it is expected that many communities will determine that layering additional teams is desirable and will provide the best overall coverage. This section outlines the position types, roles, presentation, and interventions associated with different configurations of mobile crisis response. Team types/approaches to local coverage outlined specifically include four team types: 1) investment in additional STEP-VA/BRAVO teams to achieve a quicker response in your area; 2) community care team with no law enforcement (often called the “CAHOOTS” model), 3) preventive community care team with law enforcement (in Virginia, best exemplified in Henrico’s CIT/STAR program), and 4) co-responder teams. These local teams and additional response options (e.g., telehealth options) are layered on top of the statewide STEP-VA mobile crisis coverage, for example, with additional mobile crisis coverage to respond quicker than one hour, community care teams of peers, EMTs, and/or social workers that provide an immediate response and connection to the crisis continuum, or co-responder units including law enforcement and clinicians responding to high acuity situations.

Minimum standards for community coverage include:

- *Level 1 calls must be diverted to 9-8-8*
- *Level 2 plans must include provisions for including behavioral health as a first responder (range of options described in “response options”)*
- *Level 3 plans must include coordination between agencies and provisions for including behavioral health as a first or second responder (range of options described below in “response options”)*
- *Plan must include provisions for how Level 3 calls will be handled for adults, youth and individuals with developmental disabilities*
- *Level 4 approaches must receive an emergent response, where the dispatch is not delayed*

Best practice considerations for Community Coverage are as follows. These best practices are provided for guidance only, as there are currently no established best practices when choosing among these approaches. The first three practices listed are considered best practices in implementation planning in general so are assumed to apply in a general sense to the Marcus Alert, whereas 4 and 5 are specific to the Marcus Alert.

- *Include community stakeholders in the planning process for community coverage, with a focus on stakeholders who have been impacted by the current system (such as those in a jail re-entry program, families who have lost loved ones to a mental health crisis or a police encounter, and individuals who have lived experience and are from a racial or ethnic minority background)*
- *Take a systems view and, when resources are constrained, build behavioral health focused supports as a priority over other investments*
- *Build on and integrate with other existing and emerging services and supports, such as the STEP-VA mobile crisis teams, current CIT programs and initiatives, Assertive Community Treatment or homeless outreach providers in the area*
- *Ensure there are behavioral health only approaches available at Level 3 for youth, individuals with developmental disabilities, particularly if there is a law enforcement lead for your locality's adult Level 3 primary response option*
- *Consider partnerships across jurisdictional boundaries, particularly when it increases efficiency (e.g., for any telehealth based coverage)*
- *Consider a "layered" approach, with investments aligning with community values vs. the selection of one specific team type only*

Complete List of Minimum Standards for Law Enforcement Participation in Local Marcus Alert System:

- *All localities comply with state training standards*
- *The four level framework is adopted for standard communication and response planning and integrated into the CAD*
- *Level 1 calls and situations are diverted to 9-8-8*
- *Level 2 calls are coordinated with 9-8-8*
- *Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health only response option*

- *Level 4 calls include law enforcement or EMS*
- *Memorandums of agreement (consistent with the state requirements) are developed between the call center hub and any responding law enforcement agency*
- *Submission of a plan for specialized law enforcement response addressing these four areas: leadership/organizational, basic training, intermediate training, and specialized and advanced training*
- *Specialized response across all four levels is behavioral health informed*
- *Policy regarding Marcus Alert response being utilized whenever a situation is identified as a Marcus Alert 1, 2, 3, or 4 situation (even if not initially identified)*
- *Appropriate coverage and preferential deployment of CIT officers and officers with advanced Marcus Alert training*
- *Attendance at cross-sector quarterly local meetings*
- *Submission of quarterly data (additional details under development)*

Best Practice considerations are as follows:

- *Level 1 calls are fully diverted to 9-8-8*
- *Level 2 calls follow a poison-control model with 9-8-8, unless community care teams have a special function at level 2 (e.g., “frequent utilizers” case management function)*
- *Level 3 calls involving youth are coordinated with 9-8-8 and specialized children’s mobile crisis teams*
- *Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program*
- *Back-up officers sent under agreements with regional hubs will be voluntarily CIT trained and have received the advanced Marcus Alert training*
- *At the systems level, considerations include intersections of behavioral health crisis and community policing policies and initiatives, guardian vs. warrior trainings, use of force continuum and how behavioral health crises and de-escalation are built into the use of force policy, implicit bias trainings and policies, and officer wellness supports and culture*
- *8 hour mental health first aid for all officers*
- *Ongoing de-escalation training for all officers, including basic and intermediate*
- *Interactive, scenario based de-escalation training specific to mental health scenarios, with a focus on time as a tactic, at least yearly*



- *Advanced workshop based trainings on cultural humility and cultural competence*
- *Agencies have coverage each shift by an appropriate amount of officers who have completed 40 hour CIT training in context of voluntary participation, aptitude/interest in working with individuals in behavioral health crisis, and supervisor approval. These supports can be provided in an “on call” format based on agency staff and size, but should be available for response. CIT recommends that 20% of officers are trained to achieve adequate coverage; percentage of appropriate coverage will vary based on size of agency.*
- *Agencies have coverage each shift by an appropriate amount of officers who have completed the advanced/intersectional Marcus Alert training*
- *LE integrates special requirements regarding mental health, developmental disabilities, and substance use across key agency policies such as use of force and bias-based policing*
- *High level engagement in cross sector quarterly meetings and data driven quality improvement processes at the local level*

Plan Submission

There are 10 required plan components and one optional component for areas to reach compliance by July 1, 2022. There are two supplemental documents that are important for local plan development and submission. This includes the Community Roadmap and the Marcus Alert Local Plan. The Community Roadmap provides a pathway, with both required and optional exercises, for local plan development. Resources are posted as they are finalized and can be found on the Marcus Alert website (currently under development): <https://www.dbhds.virginia.gov/marcusalert/>

The ten (and one optional) components for submission are described here. These are required to be approved by July 1, 2022 (statewide; five initial areas must have in place December, 2021). Local Marcus Alert plan submission components are:

- *Documentation of Sections 1-4 of the roadmap (when “decide and document” is noted, it should be included in your summary)*
- *List of stakeholder group members*
- *Triage crosswalk connecting 4 urgency levels to PSAP specifications*
- *Copy of Protocol #1*
- *Copy of Protocol #2*
- *Copy of Protocol #3*

- *Triage crosswalk connecting 4 urgency levels to responses/protocols 1, 2, and 3*
- *Checklist of minimum standards and best practice considerations for law enforcement involvement*
- *Statement on accountability for quarterly cross sector meetings and quarterly data reporting*
- *Contact information for application overall and core reporting, PSAP reporting contact, and law enforcement reporting contact*
- *(Optional) statement of barriers, needs, or concerns for implementation*

Summary of Section IV: Accountability and Evaluation

Section IV provides the state plan for evaluation and accountability. Cross-sector data sharing at the local and state level is one of the key challenges of evaluating the success of crisis response systems. Recently, the General Assembly allowed for a \$5 million investment in the development of a crisis call center data platform to support the coordination of crisis services across Virginia. This was put to competitive bid and the vendor will be selected in July, 2021, with the work progressing over the following six months. Thus, the technical details of the Marcus Alert reporting requirements will be developed in collaboration with the development of the broader platform. There are also a number of other considerations, such as the HJ 578 study and variation in PSAP technical operations, which support the development of a Marcus Alert Evaluation Task Force to meet for the remainder of state fiscal year 2022 to ensure that high quality data reporting is integrated into the call center platform and that this platform is accessible to all system users, including law enforcement. Membership and attendance will be asked of DBHDS and DCJS technical and program leads, crisis call center platform vendor, technical and program leads from initial area PSAPS, initial area program leads, and one subject matter expert from the initial workgroup in each of these areas: law enforcement, CIT, equity, and regional mobile crisis hub/9-8-8. Although these technical details will be under development over the next six months, some initial details are as follows.

- *Local reporting will be required on a quarterly basis. Implementing areas will need to assign an entity accountable for each of these three areas: the reporting of PSAP requirements, mobile crisis response team requirements, and law enforcement reporting requirements.*
- *Required reporting elements will include 9-1-1 calls that meet Marcus Alert level 1, 2, 3, and 4, and call disposition (CAD reporting). Field reporting will include individual information (presentation, race, age, diagnosis if available), law enforcement actions including body worn camera use, use of force, and outcomes (with a focus on connection to crisis continuum) including transportation. Once*

individuals are connected to the crisis continuum, more robust data is collected as part of the STEP-VA implementation evaluation. As mentioned, any data points which can be integrated into the crisis data platform will be.

- *A framework for local accountability is described which includes quarterly cross-sector meetings where critical incident reviews and local system development and issues will be considered. Twice yearly, a local stakeholder/community group should be convened and provided with data and reporting on the performance of the system, including racial disparities in access or outcomes, and feedback should be collected from this group for the ongoing development of the local system.*
- *State accountability framework builds on existing structures between DBHDS, CSBs, DCJS, law enforcement, and PSAPs. Ongoing planning regarding role of VDEM and OEMS.*
- *In addition to existing oversight structures, the stakeholder group will continue to meet twice yearly through 2027 to review statewide data and ongoing system development. As described in summary of State-level components, the Equity at Intercept 0 Initiative will support the development of a Black-led Crisis Coalition as well as Equity at Intercept 0 network leads who will also attend these twice yearly meetings and will continue to be involved in oversight processes each year with input into the yearly report.*
- *DBHDS and DCJS will enter into a written agreement regarding shared oversight and input on training materials for modules relevant to the success of the Marcus Alert, and will include the described entities in the review of training materials. Both of these entities (Equity at Intercept 0 leads and Crisis Coalition) will provide a written statement with feedback and recommendations for the yearly report on the implementation of the Marcus Alert that is required to the Joint Commission on Health Care.*

Conclusion

The Marcus-David Peters Act is a complex piece of legislation that defines a comprehensive crisis continuum and a local Marcus Alert system which operates to ensure that individuals in behavioral health crisis are met with a therapeutic, health-focused response and diverted to the behavioral health system. Although the overlapping timelines of these integral components of the system (9-8-8 implementation, DOJ Settlement Agreement, STEP-VA, BRAVO rates, Marcus Alert protocols) do create a complicated implementation plan, they also provide Virginia with a unique opportunity to ensure that equity and access are key considerations throughout planning and implementation.